**Wisconsin Chapter–International Association of Forensic Nurses**

# FORENSIC NURSE EXAMINER (FNE) EVALUATION OF THE ADULT/ ADOLESCENT VICTIM OF SEXUAL ASSAULT

**FORENSIC NURSE EXAMINER (FNE) EVALUATION**
**OF THE ADULT/ADOLESCENT VICTIM OF SEXUAL ASSAULT**

This guideline was developed by the Wisconsin Chapter of the International Association of Forensic Nurses. This guideline is recommended for the care of the adult/adolescent when there is a history or concern of sexual abuse or assault. Adolescents, as defined in *A National Protocol for Sexual Abuse Medical Forensic Examinations Pediatric,* are children who are Tanner stage 3 and above who have reproductive capability. A Tanner stage 3 or 4 biological female, even if premenarchal, potentially has reproductive capacity. The guideline is not intended to include all the triage issues, medical evaluations, tests, and follow-up that may be necessary for appropriate care for an individual. Not all the steps outlined in this guideline will be appropriate for every patient. The purpose of this guideline is to provide direction for FNE in the care of the adult/adolescent sexual assault patient. The goal is to ensure that compassionate and sensitive services and care are provided in a non-judgmental manner. The physical and psychological well-being of the sexual assault patient is given precedence over forensic needs. A review of the guideline by the members of the Wisconsin Chapter of the International Association of Forensic Nurses Protocol/Documentation Committee will be conducted periodically to ensure current standards of practice. See *WI-IAFN Forensic Nurse Examiner (FNE) Evaluation of the Pediatric Victim of Sexual Assault* for the assessment and care of the prepubertal child.

## I. GENERAL INFORMATION

### Purpose of Exam

**Medical/Forensic**

1. The examination does not provide routine medical care.
2. Assess for urgent health needs.
3. Identify and treat injuries. Injuries that require intervention beyond scope of practice of FNE should be referred to the physician for treatment.
4. Assess risk of pregnancy and sexually transmitted infections.
5. Provide prophylaxis for sexually transmitted infections and emergency contraception, when indicated (WI State Statute 50.375 Emergency contraception for sexual assault victims).
6. Document medical history.
7. Document the assault history, including any statements made by patient related to assault.
8. Document physical examination findings.
9. Detect, collect, and document forensic evidence.

**Social/Psychological**

1. Ensure that the patient receives information about his/her rights and his/her right to victim advocate accompaniment (WI State Statute 50.378 Victim advocates).
2. Respond to the patient's and/or family's immediate emotional needs and concerns.
3. Assess patient safety and immediate mental health needs.
4. Consider prior trauma the patient may have experienced.
5. Explain reporting process, Crime Victims Compensation / SAFE Funds and resources for advocacy and counseling.

**Consult/Report/Refer**

1. Refer for advocacy and counseling.
2. Refer for follow-up medical care.
3. In the case of minors, report to Child Protective Services (CPS) and/or law enforcement ASAP (WI State Statute 48.981 Abused or neglected children).

### Mandated Reporting

*If the patient/victim of sexual assault is an adult age 18 years and older and is competent, notification of law enforcement is done only if the patient gives his/her consent.*

**Minors and Elderly**

1. Nursing and medical providers are mandated to report any suspected child abuse to CPS and/or law enforcement ASAP when the victim is less than 18 years of age (WI State Statute 48.981 Abused or neglected children).

2. Mandatory reporting applies even when minor has signed consent for their own care.
3. Report to law enforcement in the jurisdiction where crime occurred. Contact CPS in the county in which child resides.
4. Advise patient/parent/caregiver of mandated reporting to CPS and/or law enforcement unless doing so would jeopardize the safety of other children.
5. If an adult is identified as an elder adult at risk or is a vulnerable adult and not competent to make their own healthcare decisions, reporting to Adult Protective Services should be done as outlined by the individual healthcare facility (WI State Statute 46.90 Elder abuse reporting system).
6. Document mandated reporting within the medical record.

**Consent**

*A patient seeking treatment for medical conditions related to reproductive health care may consent to such medical care or treatment at any age and without consent of parent/guardian (Title X of the federal Public Health Service Act, WI State Statute 253.07 Women's health block fund).*

1. Informed consent for procedures, evidence collection and treatments should be obtained per hospital/agency policy.
    - A hospital/agency should have a policy/consent specific for photographs.
2. If an adult patient is unable to consent for him/herself legally, hospital/agency policy should be followed in regards to who can consent for patient.
    - FNE should contact the patient's legal guardian to obtain consent.
    - The patient should assent to the exam.
3. Any patient can withdraw consent at any time and stop the examination.

**Anonymous/Undecided Reporting**

A community should have a protocol in place which allows the adult victim of sexual assault to choose anonymous reporting. Anonymous / undecided reporting allows for the collection and storage of forensic evidence until a time when the victim is able to decide about reporting his/her sexual assault to law enforcement. (Developed by WI AG SART and included in all non-reporting kits from WI Crime Lab)

## II. TRIAGE DECISIONS

***Medical stabilization of any injury or condition which may endanger the life or health of the patient always precedes forensic examination.***

**Triage**

1. The following history or conditions should be evaluated medically prior to the medical-forensic sexual assault exam includes but is not limited to:
    - Respiratory distress or difficulty
    - Abnormal vital signs
    - Active bleeding
    - Head injury
    - History of loss of consciousness
    - Altered consciousness or mental status
    - Strangulation
    - Significant facial injury
    - Possible fractures
    - Blunt or penetrating injury to chest, abdomen, pelvis or back
    - Acute pain
    - Pregnancy with complications (i.e., bleeding, decreased fetal movement, abdominal pain, etc.)
2. Psychiatric Illness

- If apparent psychiatric illness complicates assessment for reported sexual assault, both psychiatric assessment and medical exam may be necessary prior to forensic exam
  .

**Medical/Forensic Examination**

The WI-IAFN supports the following considerations for collecting evidence as developed by *A National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents (April 2013)*:

- Examiners should obtain the medical forensic history as appropriate, examine patients, and document findings when patients are willing, whether or not evidence is gathered for the sexual assault evidence collection kit.
- Examine patients promptly to minimize loss of evidence and identify medical needs and concerns.
- Make decisions about whether to collect evidence and what to collect on a case-by-case basis, guided by knowledge that time limits for obtaining evidence vary due to many factors such as what happened, what has happened since the assault, the location of the evidence or type of sample collected.
- Examiners should seek education and resources to aid in providing evidence-based information to the patient in order that the patient can make a well-informed decision about evidence collection.

**Advocacy**

FNE Programs will contact advocacy when the FNE is called and together will respond as a team.

## III. HISTORY AND INITIAL EVALUATION

*See the WI-IAFN Forensic Nurse Examiner (FNE) Adult/Adolescent Sexual Assault Documentation Form*

**Patient Information**

Document the following information if it is available and pertinent:

1. Routine data: patient name, gender, ethnicity/race, age, birthdate, medical record number, home address, phone number/contact information.
2. Date and time of arrival.
3. Parent/caregiver/guardian name, address, phone number/contact information, custody status, if applicable.
4. Name of person accompanying patient, and their relationship.
5. Interpreter name, if used and language.
6. Name of advocate and agency.
7. Name of law enforcement officer, agency and case number, if applicable.
8. Name of CPS worker and agency, if applicable.

**History of Assault**

Interview patient and document the following:

**Facts about assault**

1. Source of information (patient, police, or other person).
2. Nature of assault.
3. Time, place of assault, and jurisdiction/location if known.
4. Time since assault.
5. Number of suspects and identity of suspect(s), if known.
6. Relationship to suspect(s), if known.
7. Record narrative history of assault; include any direct quotes the patient states about the assault.
8. Whether or not photographs were taken by suspect.

**Methods used for control**

1. Patient had impaired consciousness.

2. Known or suspected alcohol/drug ingestion.
3. Verbal threats.
4. Use of physical force.
5. Use of restraints, including body weight.
6. Use of weapon, and what type of weapon.
7. Use of coercion, manipulation, grooming.
8. Strangulation and/or suffocation.

**Physical facts of sexual assault**

1. Location of physical contact on patient by suspect.
2. Body parts or objects used by suspect.
3. Whether or not a condom was used.
4. Whether or not any type of lubrication was used.
5. Any physical injuries.
6. Whether or not bleeding or pain was reported.
7. Physical contact made by patient on suspect.

**Post assault activity of the patient**

1. Whether or not the patient showered or bathed.
2. Whether or not the patient rinsed mouth, urinated, or defecated.
3. Whether or not the patient changed clothes, gave clothes to police at scene, or brought clothes worn at time of assault to emergency department/clinic.

**Past Medical History**

1. Significant medical problems, surgery, major injuries, chronic diseases, immune problems, developmental/cognitive/mental health and/or physical disabilities.
2. Current medications including over-the-counter drugs and herbal supplements.
3. Recent ingestion of other drugs, including legal and illegal substances and/or alcohol.
4. Stated height and weight.
5. Allergies.
6. Immunization status.
7. Birth control method (IUD, hormonal, barrier, surgical, etc.) and how long used.
8. OB/GYN history (last pelvic exam, vaginal delivery, surgery, etc.)
9. Last menstrual period.
10. Last consensual intercourse and with whom.

**Plan of Care**

1. Discuss medical and forensic examination with patient and parent/caregiver, if applicable.
2. Discuss use of forensic/medical photography for documentation.
3. Inform patient that written information and educational literature will be provided.
4. Discuss any mandatory reporting needs.
5. Discuss reporting choices with adult (> 18 years old) patients i.e., reporting to law enforcement, not reporting to law enforcement and undecided.
6. Discuss evidence collection choices with adult (> 18 years old) patients i.e., no evidence collection, evidence collected and given to law enforcement, evidence collected and held by WI Crime Lab (undecided choice).

## IV. MEDICAL EXAMINATION

**General Information**

1. All patients should be offered a complete head-to-toe physical examination for the purpose of injury identification and documentation.
2. It is the patient's right to consent or refuse any aspect of the exam and evidence collection at any time.
3. The patient may have a support person (relative, friend, or advocate) present during the exam. The FNE should document who was in the room during the exam.
4. Explain all procedures prior to performing them.

**Documentation of Injury**

1. Define injury i.e., abrasion, bite mark, laceration, bruise, petechiae, suction ecchymosis, et cetera.
2. Document size, shape, color, and how acquired, if known.
3. Document sites of pain even if no injury is noted. Document how pain acquired, if known.
4. Utilize a body map or anatomical diagram for documentation of injury, lesions or irregularities.
5. The patient should be informed that injury may take hours or days to become visible. If the patient notes injury that becomes visible after the FNE exam, he/she should contact the FNE or law enforcement to document the injury.

**Alternate Light Source**

1. Using alternate light source with room lights dimmed, scan patient's skin surface, including breasts, abdomen, perineum, hair, face, buttocks, thighs and ankles:
    - Document presence/absence and location of fluorescence.
    - If history indicates presence of evidence, collect blind swab from an area even if no fluorescence is noted.
2. Collect forensic swabs *(See section **V. Evidence Collection & Storage**)*.

**Forensic Photodocumentation**

Photographs can supplement the medical forensic history, evidence documentation, and physical findings. The use of photodocumentation during the examination is highly recommended for the purpose of peer review, case review, and consultation. Prior to photodocumentation, an agency should have policies for informed consent for photographs, and a procedure of how photographs will be taken, stored, and released. Informed consent must include discussion of photographs of a patient's genitals. FNE should take photographs regardless if law enforcement has taken photographs. Careful documentation with drawings is necessary even when photographs are taken. (National Protocol for Sexual Assault Medical Forensic Examinations Adult/Adolescents, April 2013)

**Exam Procedure (Head to Toe Exam)**

The following sections outline the steps for the exam and collection of evidence. The order of these steps may vary by examiner preference or patient need and guided by the scope of informed consent and the medical forensic history.

**Skin Exam**

1. Document injury, and/or any other noted lesions or irregularities.
2. Collect forensic swabs *(See section **V. Evidence Collection & Storage**)*.

**Oral Exam**

1. Check mucosa, palate, upper/lower frenula, tongue and teeth.
2. Document injury, and/or any other noted lesions or irregularities.
3. Collect forensic swabs *(See section **V. Evidence Collection & Storage**)*.

**Genital Exam – Female**

1. The external genitalia should be carefully examined and photographed prior to the speculum exam.
2. Document any genital injury, bleeding, edema, discharge, and/or degree of estrogenation, and Sexual Maturity Rating (SMR), if applicable.
3. Consider using photography, magnification and other adjuncts (colposcopy, toluidine blue dye, Foley catheter balloon technique, Q-tip, et cetera) to identify injury and assist with documentation of findings.
4. Use a vaginal speculum to visualize vagina and cervix.
5. Document any pain associated with any part of the genital exam, regardless of noted injury. Document how pain acquired, if known.
6. May rinse speculum with warm water or use a water-soluble lubricant for patient's comfort.

7. For young adolescents who have not had a prior pelvic exam or any patient that cannot tolerate a speculum exam, forensic swabs may be collected by directly inserting swabs 2-3 inches into the vagina. Do not moisten swabs for areas that are already moist.
8. Collect forensic swabs *(See section **V. Evidence Collection & Storage**)*.

**Genital Exam – Male**

1. Document penile, scrotal or perineal injury, bleeding, edema, discharge, and Sexual Maturity Rating (SMR), if applicable.
2. Document sites of pain even if no injury is noted. Document how pain acquired, if known.
3. Document if patient is circumcised.
4. Consider using photography, magnification and other adjuncts to identify injury and assist with documentation of findings.
5. Collect forensic swabs *(See section **V. Evidence Collection & Storage**)*.

**Perianal and Anal Exam**

1. Document perianal injury.
2. Document sites of pain even if no injury is noted. Document how pain acquired, if known.
3. Consider using photography, magnification and other adjuncts to identify injury and assist with documentation of findings.
4. Anoscopy is indicated if there is a report of anal assault, active rectal bleeding, suspected foreign body or rectal pain. May require physician consult.
5. Collect forensic swabs (*See section **V. Evidence Collection & Storage***).

## V. EVIDENCE COLLECTION & STORAGE

**Forensic Evidence Collection**

Wisconsin State Crime Laboratory Bureau Medical-Forensic Evidence Collection Kit is used for evidence collection. Always refer to the instructions provided within the kit prior to evidence collections. This kit is available FREE from the Wisconsin State Crime Laboratory Bureau (https://docsales.wi.gov/ - item #1205-15D). Someone is available at the Wisconsin State Crime Laboratory Bureau 24/7 to answer questions at (608) 266-2031 or (414) 382-7500.

**Chain of Custody of Forensic Specimens**

The FNE must be responsible for maintaining and documenting chain of custody of evidence collected at all times.

**Evidence Collection**

**General Information**

1. It is the patient's right to consent or refuse any aspect of the exam and evidence collection at any time during the examination. The patient's request NOT to surrender clothing, jewelry, personal items, et cetera as evidence should be respected.
2. The physical and psychological well-being of the sexual assault patient is given precedence over forensic needs.
3. Change gloves frequently during all phases of evidence collection and processing.
4. The collection of evidence is dependent upon the history of the assault and examiner discretion.
5. Envelopes may be relabeled when used to obtain swabs from sites other than those outlined in the kit.
6. The kit does not include everything that one needs to collect evidence. Materials such as scissors, tape, etc. will need to be collected from hospital/agency stock.
7. Drying of collected materials is very important as moisture enhances the proliferation of bacteria and mold which will destroy biological and trace evidence. Drying may be accomplished by air drying or by the use of a drying box. Use of a drying box requires the development of policy which addresses the cleaning of the box and the methods used to prevent cross contamination of the swabs. Law enforcement should be informed of items which require further drying.

8. Collect evidence which may be compromised by time or examination FIRST such as oral swabs and floss (in cases of an oral assault) and fingernail evidence.
9. NEVER LICK evidence envelopes to seal. Use sterile or tap water.
10. NEVER STORE evidence swabs or debris or clothing in plastic bags or airtight containers. Items should be collected in separate paper or breathable bags or containers.

**Wisconsin Crime Lab Information Sheet**
(Included in Wisconsin State Crime Laboratory Bureau Medical-Forensic Evidence Collection Kit)
1. Fill out all information requested on form.
2. Please note if the patient is known to have had a vasectomy, is a twin or is a bone marrow recipient.
3. The FNE should sign and date the form where indicated.

**Pre-Void External Genital Wipe**
1. Collect if any history of contact to the genitals occurred or suspected.
2. Instruct the patient to wipe the genital area with the 4 X 4 gauze prior to voiding.
3. Once gauze is air dried, return it to the envelope.
4. Seal and fill out all information requested on the envelope.

**Optional Toxicology**
If a drug and/or alcohol facilitated sexual assault is suspected, specimens for analysis should be collected and sent to the Wisconsin Crime Laboratory as soon as possible. The Wisconsin State Crime Laboratory Bureau Toxicology Kit is used for evidence collection.
1. Collect when drugs and/or alcohol are suspected of being ingested and the victim lost consciousness or had a significant period of memory loss that is not explainable, unexplained lethargy noted by victim or others, et cetera.
2. Optional toxicology is NOT collected if the patient is undecided/non-reporting.
3. Blood and urine should be collected if within 24 hours of suspected drugging. If greater than 24 hours since suspected drugging, ONLY urine should be collected. Urine can be collected up to 96 hours from the suspected ingestion.
4. Blood sample—Fill two (2) 10 ml gray-top tubes with blood. The minimum amount of blood needed is 5ml.
5. Urine Sample—Obtain urine as soon as possible. Collect the urine from the patient according to hospital/agency protocol. Fill two (2) 10ml gray-top tubes with the collected urine.
6. Seal and initial the samples by placing a patient label or evidence tape over the stopper to avoid tampering. Place tubes inside a sealed plastic bag to retain any leakage. Place inside the biological mailing container. Do NOT place these samples in the Wisconsin State Crime Laboratory Bureau Medical-Forensic Evidence Collection Kit. Fill out all information requested on the Wisconsin Crime Lab Information Sheet and the label for the biological mailing container.
7. Transfer specimens to law enforcement to be processed by the Wisconsin Crime Lab. Do NOT send these samples to the State Laboratory of Hygiene.
8. Blood and urine samples must be kept refrigerated if not taken to the Crime Lab immediately.
9. Wisconsin Crime Lab toxicology results are not reported to the healthcare facility and do not become a part of the patient's medical record.

**Oral Swabs and Floss**
Collect ASAP when abuse/assault occurred or visible oral injury or history of oral/genital contact.
1. Collect 2 swabs; thoroughly swab the oral cavity, especially between the cheeks and gums.
2. Allow swabs to thoroughly air dry.
3. Place dry swabs in original swab package.
4. Place swab package in envelope.
5. Seal and fill out all information requested on the envelope.

6. Unwaxed dental floss can be used for areas between the teeth. Have the patient floss his/her own teeth *using a minimal amount of floss.* Place used dental floss in envelope labeled Floss.

*An HIV risk assessment is standard procedure in a SANE examination. If this risk assessment determines that the patient is at risk for the possible transmission of HIV, the use of dental floss should be omitted. Reference – *IAFN Position Statement on DNA Evidence Collection from the Oral Cavity*, September 2013

**Buccal Cell Standard (DNA)**
Collect reference oral standard swabs to establish patient DNA. The goal is to collect as many cells from the inside cheek of the patient as possible.
1. Rinse mouth with water prior to collecting sample.
2. Using one swab, place the swab in solid contact with the inner cheek and gum surface.
3. Gently move the swab up and down/back and forth five or six times, rotating the swab while rubbing.
4. Repeat process with a second swab on the other inner cheek and gum surface.
5. Allow the swabs to thoroughly air dry.
6. Return the dried swabs to the original swab package.
7. Place swab package in envelope.
8. Seal the envelope and fill out all information requested on envelope.

**Fingernail Evidence**
Collect if patient reports scratching assailant or examiner believes nail debris may be related to assault. Obtain when visible debris or blood under nails, nails broken during assault and/or history suggests patient scratched assailant.
1. Evidence from each hand should be collected individually.
    - Place small paper sheet on flat surface.
    - Using tapered cotton swab slightly moistened with sterile water, swab under all five fingernails of left hand (or right), allowing any debris to fall onto paper.
    - Repeat swabbing under the fingernails with a second lightly moistened swab.
    - Allow swabs to thoroughly air dry.
    - Place dried swabs in original swab package.
    - Bindle paper (fold all edges inward so that there are no open edges) to retain debris.
    - Seal the envelope and fill out all information requested on envelope.
2. Place paper and swabs from each hand in a separate labeled envelope.

**Trace Evidence/Collection Paper**
To collect foreign material that may dislodge when patient undresses:
1. Place bed sheet or large paper sheet on floor. This is to prevent floor debris from adhering to evidence collection paper.
2. Place evidence collection paper over the sheet on the floor. Evidence collection paper is not included in the kit.
3. Instruct patient to stand in the center of paper and remove clothing (See *Clothing Collection*).
4. After clothing collected, collect the evidence collection paper sheet. Bindle sheet (fold all edges inward so that there are no open edges) retaining any foreign material and place in paper bag as forensic evidence.
5. Label paper bag with contents. Place patient identifying information on bag, fold top of bag multiple times, tape bag closed securely to avoid tampering, and sign over tape.

**Clothing Collection**
If assault occurred outdoors, or clothing was stained or damaged during assault, collection is particularly important.
1. Collect the clothes the patient was wearing during or immediately after the assault.
2. Always collect patient's underwear even if changed or laundered after assault.
3. Do not cut through any existing holes, rips or stains on clothing.

4. Do not shake out victim's clothing as trace evidence may be lost.
5. Do not fold wet or bloody clothing in a way which will transfer the blood or fluid to another site on the clothing – layer paper and/or linen prior to folding to prevent transfer.
6. Consider taking photographs of clothing if any unusual findings are present such as rips/tear, body fluids, debris, etc.
7. Place each item of clothing in a separate paper bag labeled with contents.
8. Place patient identifying information on each bag, fold top of bag multiple times, tape bag closed securely to avoid tampering, and sign over tape.
9. Document all clothing collected and document anything unusual about clothing, i.e., rips, stains, bites which occurred through clothing, etc.
10. Maintain chain of custody for clothing bags. Place in secured area when not directly observed.
11. If the patient is choosing the undecided reporting option, the only clothing to be collected are undergarments (panties). The undergarments are placed directly into the kit.

**Other Items**
Collect items which may contain forensic evidence, such as adult diaper, menstrual or urine pads, tampons, condoms, genital/body piercings, diaphragm, sponge, etc. These should be collected on a case-by-case basis. Contact the Wisconsin Crime Lab for further drying and storage instructions, if needed.
1. Air-dry the item if possible. If unable to air-dry, package the item in a non-airtight container, such as a urine cup with holes in the lid to allow the item to dry.
2. Place patient identifying information on container/envelope/bag and store with kit or in separate bag.

**Skin to Skin Contact**
Examples of skin to skin contact may be strangulation, grabbing, scratching. The goal is to maximize the potential evidence on as few swabs as possible.
1. Skin cells should be collected by gently swabbing or rolling the contact area with two cotton tipped swabs moistened with sterile water.
2. The swabs should be air dried, placed in the original swab package, and then placed in the envelope.
3. Seal and fill out all information on the envelope.

**Debris**
Collect when foreign material is visible on patient's skin or hair and patient reports, or examiner believes, debris is related to the assault.
1. Collect any foreign debris (dirt, leaves, fiber, hair, etc.).
2. Separate debris – Do NOT collect unlike debris from one site or like debris from different sites in the same envelope.
3. Note site from which debris is obtained on the envelope.
4. Seal the envelope and fill out all information requested on envelope.

**Dried Secretions**
Examples of dried secretions include saliva on a bite mark, dried blood, area kissed or licked, et cetera.
1. To obtain swabs from dry areas that may contain suspect DNA:
    - Lightly moisten two swabs with sterile water (soaking in water will prolong drying time and increase likelihood of specimen molding) and swab area of interest.
    - Allow swabs to thoroughly air dry.
    - Place dry swabs in original swab packages and then into appropriate envelope.
    - Document on envelope the site from which specimen is obtained.
    - Seal the envelope and fill out all information requested on envelope.

**Pubic Hair Combings**
*Omit if not present or if it has been shaved.*
To collect foreign hairs and debris:

Patient should be sitting or lying in dorsal lithotomy position.
1. Place paper sheet under the patient's pubic region.
2. Using disposable comb, comb pubic hair in downward strokes so any loose hairs and/or debris will fall onto paper.
3. Pubic hair containing a large amount of material/substance may be cut and collected.
4. Bindle paper to retain both comb and any evidence present and place in appropriate envelope.
5. Seal the envelope and fill out all information requested on envelope.

**Pubic Hair Standards or Mons Pubis Swabs**
*DO NOT PLUCK PUBIC HAIR!*
The patient may collect his/her own pubic hair standards as long as he/she follows the procedures described below and is supervised by FNE.
1. Obtain at least twenty (20) hairs by cutting hairs at the skin surface. The hairs should be collected from various areas within the pubic region.
2. Place the hairs in the paper fold and then insert into the Pubic Hair Standards envelope.
3. Seal the envelope and fill out all information requested on envelope.
4. If the patient does not have pubic hair, swab the mons pubis. The sample should be collected by gently swabbing the area with two swabs slightly moistened with sterile water
5. The swabs should be air dried, placed in the original swab package, and then into the envelope.
6. Seal and fill out all information on the envelope.

**External Genital Swabs**
The goal is to maximize the potential evidence on as few swabs as possible.
1. Swab the entire external genital area. This sample should be collected by gently swabbing the area with two cotton tipped swabs slightly moistened with sterile water.
2. The swabs should be air dried, placed in the original swab package, and then into the envelope.
3. Seal and fill out all information requested on the envelope.

**Vaginal Swabs**
Collect when:
1. History of penile-genital or oral-genital contact **OR**
2. Report of contact to genitalia, perineum by any part of assailant's body **OR**
3. Ejaculation occurred near anogenital area **OR**
4. Visible acute genital injury **OR**
5. Alternative light source scan is positive in anogenital area

Procedure:
1. Using four sterile swabs simultaneously, thoroughly swab the vaginal vault.
2. Allow swabs to thoroughly dry.

When swabs are dry:
1. Place all four swabs in their original swab packages and then into the envelope.
2. Seal the envelope and fill out all information requested on envelope.

**Cervical Swabs**
Collect when:
1. History of penile-genital or oral-genital contact **OR**
2. Report of contact to genitalia, perineum by any part of assailant's body **OR**
3. Ejaculation occurred near anogenital area **OR**
4. Visible acute genital injury **OR**
5. Alternative light source scan is positive in anogenital area.

Procedure:
1. Place 2 swabs next to or at the opening of the cervical os (NOT in the os) for 10-15 seconds picking up the cervical mucous and then swab the posterior fornix from 3-9 o'clock with the same swabs.

When swabs are dry:

1. Place swabs in original swab package.
2. Place swab package into appropriate envelope.
3. Seal the envelope and fill out all information requested on envelope.

**Penis Swabs**
When collecting penile swabs, the entire external area of the penis should be swabbed. Care should be taken to avoid the area around the urethral opening.
1. Swabs of the penis should be collected by gently swabbing or rolling the entire penis with two cotton tipped swabs moistened with sterile water.
2. The swabs should be air dried, placed in the swab package, and then into the envelope.
3. Seal and fill out all information on the envelope.

**Anal Swabs**
These swabs are obtained from the anus and anal area. The envelope should be relabeled if obtained from the rectal area.
Collect when:
1. Report of contact to anus by any part of assailant's body **OR**
2. Ejaculation occurred near anogenital area **OR**
3. Visible acute anal injury **OR**
4. Alternative light source scan is positive in anogenital area.

Procedure:
1. Lightly moisten two swabs with sterile water if area is dry.
2. Using two swabs simultaneously, thoroughly swab the anal area.
3. Allow swabs to thoroughly air dry.

When swabs are dry:
1. Place both swabs in original swab package
2. Place swab package into appropriate envelope.
3. Seal the envelope and fill out all information requested on envelope.

**WI Crime Lab Evidence Collection Sheet / Inventory Form**
Complete the *WI Crime Lab Evidence Collection Sheet/Inventory* form provided in the kit. Note the kit number on the evidence collection sheet/inventory. Place the evidence collection sheet/inventory form in the kit. A copy of this evidence collection sheet/inventory should also be placed in the patient's medical record.

**Completing Evidence Collection Kit**
1. Once all evidence has been obtained and placed inside the kit:
    - Complete all information requested on the front of the kit.
    - Give the kit to the law enforcement representative and have him/her sign the front of the kit.
2. If no law enforcement representative is available:
    - Follow the hospital/agency policy that is in place.
    - Store the kit in a secure area.
    - Contact law enforcement immediately and give them the location of the completed kit so they are able to pick it up ASAP.

**<u>Evidence Storage</u>**
**Temperature**
1. Dry evidence is stored at room temperature.
2. Damp or wet evidence specimens should be thoroughly air dried. If this is not possible, these specimens must be given to law enforcement with instructions for further drying.
3. A deissicant pouch is included in the kit to facilitate further drying of specimens in the kit. Follow kit instructions regarding use of the deissicant pouch.
4. Blood tubes and/or urine specimens (toxicology) must be kept refrigerated if not taken to the Wisconsin Crime Lab immediately.

**Clothing**

1. Each piece of dry clothing should be placed in a separate paper bag, sealed with tape, signed over seal, and labeled with patient ID and contents.
2. Wet clothing should be dried completely – this may be done by law enforcement after FNE exam.

**Completing Evidence Collection Kit if Patient is NOT reporting to Law Enforcement**

1. In Wisconsin, the adult patient can decide to have evidence collected and NOT report the assault to law enforcement at the time the FNE exam is done.
2. The evidence collected is sent to the WI Crime Lab and will be stored for 10 years
3. Optional toxicology is NOT collected and the only clothing collected are undergarments (panties).
4. Undecided/Non-Reporting Kits are available FREE from the WI Crime Lab. Instructions, forms and a mailing container are included in the kit. The Wisconsin State Crime Laboratory Bureau Medical-Forensic Evidence Collection Kit is used to collect evidence.
5. The patient must complete the *Medical Forensic Exam with Evidence Collection: Information and Options* form. This form is given to the patient and a copy of the form is to be placed in the patient's medical record.
6. The *Transmittal of Evidence* form is completed and it and the completed evidence collection kit are placed in the mailing container and sent to the Wisconsin Crime Lab.
7. The Crime Lab will send confirmation of kit received to the FNE Program. This confirmation should be placed in the patient's medical record.

## VI. DIAGNOSTIC TESTS

**Pregnancy Test**

Obtain urine or serum pregnancy test on all patients at risk for pregnancy.

**Urinalysis**

If urinalysis needed, request that lab look for and report the presence of sperm.

**Hospital Toxicology Tests**

If toxicology and/or alcohol results are needed for patient care, hospital/agency toxicology testing should be done. Consider obtaining toxicology and/or alcohol level when:

- Patient appears impaired, intoxicated, has altered mental state or there is question of patient's ability to consent/participate in the medical forensic examination.
- Patient reports unexplained blackout, memory lapse, or partial or total amnesia for event.
- Patient or other is concerned that he/she may have been drugged.
- Samples for toxicology should be obtained ASAP.
- If toxicology is not needed for patient care but is needed for forensic purposes, use the Wisconsin State Crime Laboratory Bureau Toxicology Kit.

**Vaginal Wet Mount**

1. May be used to assess vaginitis if signs and symptoms are present.
2. Request that lab check and report presence of sperm.

**Sexually Transmitted Infection (STI) Tests for Gonorrhea and Chlamydia**

1. STI testing per hospital/agency policy.
2. STI testing, if done at time of acute assault, should be repeated at follow-up visit if the patient does not take prophylaxis for Gonorrhea and Chlamydia or is symptomatic.
3. Specimens for STI testing go to hospital/agency lab, NOT Crime Lab.
4. Inform patient these tests are related to health issues and are not exclusively for forensic purposes.
5. Positive tests may indicate pre-existing infection.
6. For vaginal or penile infection:

- Collect urine, cervical, or penile/urethral swabs for Nucleic Acid Amplification Test (NAAT)
- Or swab vaginal/cervical or penile areas for culture
- If results to be used for forensic purposes, a positive NAAT must be confirmed (prior to treatment) by culture or by a different NAAT which detects a different DNA / RNA sequence.

7. For anal infection:
    - Culture for gonorrhea and chlamydia
8. For pharyngeal infection:
    - Culture for gonorrhea
    - Do not culture for chlamydia

**STI Tests for Syphilis and Syphilis Serology**

The decision to test for Syphilis should be made on a case by case basis and should be referred to the primary care provider if follow-up and/or treatment needed.

**HIV Testing**

HIV risk assessment is part of the SANE examination. The decision to test for HIV should be made on a case by case basis, depending on the likelihood of infection of the assailant(s).

1. Risk factors of assailant regarding HIV, if known
    - Known or suspected intravenous drug user.
    - If male assailant has had sex with men
    - If assailant is from an endemic area
    - History of multiple sex partners
    - History of incarceration in prison
    - History of prostitution.
    - History of STI
2. Evaluate circumstances for HIV transmission - blood or mucous membrane exposure.
3. Review community epidemiology.
4. HIV testing and Post-Exposure Prophylaxis should be done per hospital/agency policy and CDC Guidelines.
5. Resource – HIV PEP Clinician Consultation Center www.nccc.ussf.edu

**Hepatitis Serology**

The decision to test for Hepatitis B and C should be made on a case by case basis and should be referred to the primary care provider if follow-up and/or treatment needed

## VII. TREATMENT

**Emergency Contraception / Pregnancy Prevention**

1. Every patient who is at risk for pregnancy will be offered emergency contraception for pregnancy prevention
2. Document on the medical record that the patient is provided with information about emergency contraception and if the patient accepts or declines pregnancy prophylaxis.
3. Resource - WI State Statute 50.375 Emergency contraception for sexual assault victims

**Offer emergency pregnancy prophylaxis when:**

1. Patient is at risk for pregnancy and pregnancy test is negative.
2. Emergency contraception (EC) must be given within 120 hours of a sexual assault to be effective. The sooner that EC is given the more effective it (EC) is.

**STI Prophylaxis**

Every patient should be offered prophylactic treatment for sexually transmitted infections per current CDC Guidelines. http://www.cdc.gov/std/treatment/2015/sexual-assault.htm

**Hepatitis B Vaccine**

Offer when:

1. Patient has not been previously fully immunized for Hepatitis B **AND**
2. Patient has a negative history of Hepatitis B **AND**
3. Secretion-mucosal contact has occurred during assault **AND**
4. Patient signs consent for immunization.
5. Inform patient that repeat vaccine doses are necessary at one month and six months after initial vaccine.

**Tetanus Vaccine**

Offer when:

1. Skin wounds occurred during assault **AND**
2. Patient is not up to date for Tetanus immunization (no immunization in past 10 years)

**HIV Prophylaxis**

*The patient will be offered information regarding HIV and appropriate medical follow-up for HIV. Prophylactic treatment for HIV may be started in the emergency department if the emergency department has HIV PEP protocols in place.*

1. All patients will receive HIV risk assessment. Generally, prophylaxis is not recommended, except in cases considered high risk:
    - Assailant is a gay or bisexual male, IV drug user, prostitution history or from an endemic area.
    - Assailant is known to have HIV.
    - Multiple assailants
2. Hospital/agency should have protocol and HIV PEP available, medications need to be started within 72 hours of assault.
3. WI State Statues allow for court ordered testing of a suspect for HIV, STI's (WI State Statute 252.11 *Sexually transmitted disease* and 252.15 *Restrictions on use of an HIV test).*

## VIII. DISCHARGE AND FOLLOW-UP CONTACT

**Discharge**

1. Discuss safety issues/plan
2. Appropriate medical follow-up will be identified for the patient with respect to the evaluation of possible sexually transmitted infections, pregnancy and any physical injuries sustained during the assault.
3. Explain follow-up for test results
4. Offer patient educational materials
5. Confirm plans for medical and counseling follow-up
6. Give phone number for sexual assault victim advocate and other support services
7. Follow-up counseling information will be provided to the patient by the sexual assault advocate or the forensic examiner
8. Give written discharge instructions for ALL treatment and follow-up
9. Information on area resources concerning medical follow-up, crisis intervention phone numbers, sexual assault crisis centers, shelters, CPS, Crime Victims Compensation Program, law enforcement and the district attorney's office will be given to the patient at the time of discharge.

**Follow-Up by FNE**

Telephone contact is recommended to take place within two weeks of the initial exam. Review with patient or parent/caregiver:

- Exam findings as appropriate
- Lab results
- Current physical symptoms
- Emotional reactions (sleep disorders, anxiety, depressive symptoms, flashbacks, other)
- Concerns for safety

- Concerns regarding STIs and HIV
- Additional history or any new information regarding the assault
- Assess need for referral for further medical follow-up, mental health, social services, et cetera.
- Document follow-up contact and additional referrals made

**RESOURCES**

*A National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents* (April 2013)

*A National Protocol for Sexual Abuse Medical Forensic Examinations Pediatric* (April 2016)

International Association of Forensic Nurses, www.iafn.org

National Domestic Violence Hotline……..……..800.799.SAFE

National Sexual Violence Resource Center, www.nsvrc.org

Rape and Incest National Network (RAINN)…….……..800.656.HOPE

Sexual Assault Forensic Examiner Technical Assistance, www.safeta.org

Wisconsin Coalition Against Sexual Assault (WCASA), www.wcasa.org…608.257.1516

End Domestic Abuse Wisconsin, www.endabusewi.org

Wisconsin State Crime Laboratory Bureau Medical-Forensic Evidence Collection Kit

Wisconsin State Crime Laboratory Bureau Toxicology Kit

**Completed on March 1, 2006 by the members of the Wisconsin Chapter of the International Association of Forensic Nurses Documentation/Protocol Subcommittee:** C. Jill Poarch, RN, BSN, SANE-A (Chair, WI-IAFN Documentation/Protocol Subcommittee), Theresa Backman, RN, MSN, Jacqui Callari-Robinson, RN, BSN, Sue Chiapete, RN, BSN, Jean Coopman-Jansen, RN, CEN, Amy Edwards, RN, BSN, Saskia Lodder, RN, BSN, SANE-A, Kim Macaulay, RN, BSN, SANE-A, Colleen O'Brien, RN, MS, SANE-A, Sharon Pribbernow, RN, Julie Schuppel, RN, Virginia Squires, RN, ADN and Vickie Vanden Heuvel, RN

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